



from EVIDENCE to POLICY

a note series on learning what works, from the Human Development Network

Can Cash Transfers Help Children Stay Healthy?

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Societies have a stake in ensuring that their youngest populations receive regular health check-ups and proper medical care when needed. Children whose health is protected and nurtured have a better chance of enrolling in school, learning, and growing to be healthy and productive adults, which in turn helps a country's development. So how can policymakers and development experts promote this? Increasingly, cash transfers are being used to encourage families to take basic preventive care measures, including regular health care visits for babies and young children and enrolling children in school. The transfers may be conditional, meaning families get the money if they take children for regular check-ups or enroll them in school; or they can be unconditional, in which case families receive the money without any strings attached, under the assumption that the extra cash will give parents the financial flexibility to ensure proper health visits and schooling. While both methods are being used in developing countries, there is still a need for information on which works best and under what circumstances.

The World Bank is committed to helping countries protect and nurture children's health and education, two of the eight United Nations Millennium Development Goals. To help policymakers better understand what methods work, the World Bank supported a study of a pilot cash transfer program in Burkina Faso to encourage families to bring their children to health clinics for regular growth monitoring and to send them to school. The evaluation found that conditional cash transfers boosted routine preventive health care visits, regardless of whether the money was given to the mother or father. On the other hand, unconditional cash transfers, regardless of which parent received the money, did not lead to more regular health visits. Conditional cash transfers can be more expensive and complex to implement than unconditional transfers and policymakers may take this into account when devising programs. But it's always important to look at outcomes as well when deciding how to create and implement programs.

Case Study Burkina Faso

A two-year pilot program, the Nahouri Cash Transfers Pilot Project, was implemented in Burkina Faso's southern Nahouri province, about 100 miles from the country's capital. The project used conditional and unconditional cash transfers to encourage poor families to enroll their children in school and take them for regular health check-ups. A random experimental design was incorporated into the pilot to allow for evaluation of the relative effectiveness of the different cash transfer programs.

As part of the pilot, 75 villages with primary schools program were randomly allocated to one of five groups. In the first, fathers received the conditional cash transfer; in the second group, mothers received the conditional cash transfer; in the third group, father received an unconditional cash transfer; in the fourth group, mothers received it; and the fifth group was the control group. Only poor households qualified for the transfer program, and their eligibility was determined using a combination of Burkina Faso national household data and a survey that looked at asset ownership, education, living conditions, and economic activities. Qualifying households were assigned to either receive or not receive the particular transfer through a lottery system. In all cases, researchers met with village leaders to explain the program, which helped maintain

Did You Know...

Close to 80 percent of people in Burkina Faso live in rural areas...
...compared with 62 percent for Sub-Saharan Africa overall.
But, overall, the immunization rate for children is around 95 percent.



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participation and build support. In total, about 3200 households took part in the pilot project.

The conditional cash transfer had a health and schooling component. The money was distributed on a per child basis and the amount differed based on the age of the child. To receive the money, children under the age of six had to have quarterly health clinic visits for child growth monitoring, and children aged seven through 15 had to be enrolled in school and show a 90 percent or better attendance rate. Households that qualified for an unconditional cash transfer received a quarterly stipend for each child, regardless. In both cases, the stipend was the same: approximately \$9.64 for a full year for a child under the age of 6; about \$19 a year for each child be-

tween the ages of 7 and 10; and almost \$38 a year for children between the ages of 11 and 15. There was no cap on the total amount a household could receive. Families who qualified for conditional cash transfers received booklets that were stamped by teachers and health-care workers to show school enrollment and health care usage.

This part of the two-year evaluation, which began in 2008 with a baseline survey, looked only at the usage of routine health services (as opposed to quarterly clinic visits to monitor a child's growth). Results are forthcoming in other areas of the impact evaluation, including the effect of cash transfers on schooling and other impacts.

Why Burkina Faso?

Even when compared with other developing countries in Sub-Saharan Africa, Burkina Faso's some 15 million people have very poor health and economic opportunities and outcomes. Close to 50 percent of people live at or below the national poverty line; per capita GDP is below the average for developing countries in the region; and life expectancy is 55 years.

Health care is likewise poor. Some 35 percent of children under the age of 5 are malnourished based on height for age and 36 percent of the population has access to basic health care. The health system is understaffed, based

on national data, and only 60 percent of births are attended by a trained health care provider. The probability of a child dying before reaching his or her fifth birthday is also among the highest in the region, although it declined to 176 per 1,000 live births in 2010 from 188 per 1,000 in 2002. This is still high compared with other developing countries in Sub-Saharan Africa, which as a whole saw a drop in under age 5 mortality from 148 per 1,000 in 2002 to 121 per 1,000 (for the world as a whole, the average is 58).

The Findings

Conditional cash transfers boosted preventive health care visits for children by more than 40 percent...

Children under the age of five years old had 0.43 more routine health care visits than children in the control group households. This represented a 42 percent increase

over the average number of routine visits, which was 1.03 visits a year

... and it didn't matter whether fathers or mothers received the money. In both cases, the number of routine visits rose.

This bulletin is based on the paper, "Alternative Cash Transfer Delivery Mechanisms: Impacts on Routine Preventative Health Clinic Visits in Burkina Faso," by Richard Akresh, Damien de Walque and Harounan Kazianga (Policy Research Working Paper Series 5958, The World Bank). The pilot project was funded by, among other funds, the Spanish Impact Evaluation Fund and the Bank-Netherlands Partnership Program.



There are long-standing questions whether it's more effective to give conditional cash transfers to mothers or fathers. This evaluation found that there was no statistically significant difference. When money was given to fathers, children had 0.415 more visits to health clinics. When the money was given to mothers, the number of visits rose by 0.446.

Nor was the gender of the child significant when it came to the effect of conditional cash transfers.

There was suggestive evidence that when fathers received the money, there was a bigger impact on routine health clinic visits for girls (an additional 0.580), while transfers to mothers had a larger impact on health clinic visits for boys (an additional 0.505 visits). However, the difference is not statistically significant.

The impact of conditional cash transfers was the same whether the household receiving the money was classified as "extremely poor" or "less poor."

Households that were eligible to receive the cash transfers all were below the estimated national poverty line. Extremely poor households are defined as being below the median household per capita expenditure level in the baseline survey. There were no significant differences between the impacts for cash transfers given to extremely poor or less poor households.

Unconditional cash transfers didn't have the same effect. There was no significant impact on use of routine health-care services.

Regardless of whether the unconditional cash transfer was given to mothers or fathers, there was no increase in the number of regular health clinic visits of their children. In both cases, children in households receiving unconditional cash transfers were no better off than those in the control group.

The impact of conditional cash transfers on health care visits was driven by increased visits for older children, aged 24 to 59 months.

This may be because parents already were bringing their younger children in for fairly regular visits. On average, babies in Burkina Faso have 1.43 visits a year, compared with 0.80 visits for children aged two to five. So there was more room to improve when it came to bringing older



children for check-ups. When broken down by age, conditional cash transfers increased the number of visits for older children by between 70 percent and 79 percent, depending on whether the mother or father received the transfer.

Conclusion Making policy from evidence

Cash transfers are being used across the world to encourage better use of education and health services by offering economic incentives that can significantly boost the incomes of poor households. This effect has been seen in programs in other countries, such as the Progresa/Oportunidades program in Mexico, which gives families cash transfers in exchange for ensuring their children are enrolled in school and receive proper health care. In some cases, what is transferred is not cash but food, which has also been successfully used in, for example, Burkina Faso and Uganda (see previous Evidence to Policy Notes), to raise student enrollment.

Transfer programs can be conditional or unconditional, and development experts are still evaluating which works best and under what circumstances. Unconditional cash transfers are easier and less expensive to implement, which can make them very cost-effective. But the lack of conditionality means less control over ensuring the intended audi-

ence – usually pregnant women and children – get the care or education that is intended. In Burkina Faso, conditional cash transfers successfully boosted routine health clinic use. By contrast, unconditional cash transfers didn't raise the number of health care visits by any significant degree.

From a policy perspective, conditional cash transfers did successfully encourage greater use of routine health-care. In this pilot in Burkina Faso, families also received cash transfers for enrolling and sending older children to school, which may have had an impact on the use of health care services (perhaps because parents whose older children are in school have either more time or more opportunities to take younger children to a health clinic). Additional evaluations will look at other aspects of the program, while further evaluations are likely needed to measure whether cash transfers linked solely to health clinic visits are equally effective.

The Human Development Network, part of the World Bank Group, supports and disseminates research evaluating the impact of development projects to help alleviate poverty. **The goal is to collect and build empirical evidence that can help governments and development organizations design and implement the most appropriate and effective policies for better educational, health and job opportunities for people in developing countries.** For more information about who we are and what we do, go to: <http://www.worldbank.org/hdchiefeconomist>

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